Commonwealth of Massachusetts
Division of Medical Assistance
600 Washington Street
Boston, MA 02111

Name of Patient: _____
(please print)

HYSTERECTOMY INFORMATION FORM

Instructions to Providers — Each provider requesting payment for any portion of a hysterectomy must attach a completed HI-1 form to the claim form. When more than one provider is requesting payment for the same hysterectomy, a photocopy of the completed form may be submitted in lieu of the original.

A. HYSTERECTOMY INFORMATION

A hysterectomy is an operation in which a woman's uterus (womb) is removed. A hysterectomy should be done only when there is a disease or injury of the uterus (or some other medical problem) that can only be treated by removing the uterus. Your doctor should explain to you why a hysterectomy is needed and what discomforts, risks, and benefits may result from the surgery.

If you have a hysterectomy, you cannot become pregnant or bear children. A hysterectomy is permanent and cannot be reversed.

MassHealth requires that a second doctor examine you before you have a hysterectomy. The reason for this requirement is to make sure you have enough information to decide whether or not you want to have a hysterectomy.

If the reason you are having a hysterectomy is to avoid bearing children, you should consider other methods of sterilization, such as tubal ligation (having your tubes tied). **MassHealth will not pay for a hysterectomy if the purpose is for birth control.** A hysterectomy takes much longer to do than a tubal ligation, and you would be in the hospital longer. There is more discomfort and a greater chance of serious health problems with a hysterectomy.

B. ACKNOWLEDGEMENT THAT HYSTERECTOMY INFORMATION WAS RECEIVED

Federal regulations (42 CFR 441.255) require that a MassHealth member having a hysterectomy sign written acknowledgement that information about hysterectomies was received before the operation was performed.

Acknowledgement That Hysterectomy Information Was Received

I have read the above information about the hysterectomy operation. A medical person has also explained hysterectomies to me. The discomfort, risks, and benefits that go along with a hysterectomy have been explained to me. All of my questions have been answered to my satisfaction.

I understand that if I have a hysterectomy operation I cannot become pregnant or bear children. I understand that a hysterectomy is permanent and cannot be reversed.

Signature of Member or Representative: _____

Date: _____ *Relationship of Representative to Member:* _____

Name of Physician: _____ **Name of Patient:** _____
(please print) *(please print)*

C. PHYSICIAN'S CERTIFICATION

Federal regulations (42 CFR 441.255) do not require the patient's prior acknowledgement when the patient was sterile before the hysterectomy or in the case of emergency surgery. In such cases, the physician who performed the hysterectomy must certify in writing that one of the following circumstances existed at the time of the surgery.

Check the appropriate box below if any of the following circumstances is applicable and complete that section of the form **only.**

☐ **1. Prior Sterility**

I certify that the above-named member was sterile before the hysterectomy and that the cause of sterility was:

_____

(Date of Hysterectomy) (Signature of Physician Who Performed Hysterectomy) (Date Signed)

☐ **2. Emergency Surgery**

I certify that because of a life-threatening emergency it was not feasible or realistic to require the acknowledgement of the above-named member before the hysterectomy. The nature of the emergency was:

_____

(Date of Hysterectomy) (Signature of Physician Who Performed Hysterectomy) (Date Signed)

D. PHYSICIAN'S CERTIFICATION FOR RETROACTIVE ELIGIBILITY

Check the appropriate box below if any of the following circumstances is applicable and complete that section of the form **only.**

☐ **1. Retroactive Eligibility: Informed Member**

The above-named patient was not a MassHealth member on the date on which the hysterectomy was performed. However, I informed the patient before surgery that the operation would make her sterile.

(Date of Hysterectomy) (Signature of Physician Who Performed Hysterectomy) (Date Signed)

☐ **2. Retroactive Eligibility: Prior Sterility**

The above-named patient was not a MassHealth member on the date on which the hysterectomy was performed. However, I certify that the patient was sterile before the hysterectomy and that the cause of sterility was:

_____

(Date of Hysterectomy) (Signature of Physician Who Performed Hysterectomy) (Date Signed)

☐ **3. Retroactive Eligibility: Emergency Surgery**

The above-named patient was not a MassHealth member on the date on which the hysterectomy was performed. However, I certify that because of a life-threatening emergency it was not feasible or realistic to require the patient's acknowledgement before the hysterectomy. The nature of the emergency was:

_____

(Date of Hysterectomy) (Signature of Physician Who Performed Hysterectomy) (Date Signed)